U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 06Feb2001

Case No: 2000-BLA-0053

In the Matter of

ROBERT J. FINGER, Individually

and

JOANN FINGER, Widow of
ROBERT J. FINGER, Deceased

Claimants

v.

ZEIGLER COAL COMPANY

Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS

Party-in-Interest

APPEARANCES:

Thomas E. Johnson, Esq.
JOHNSON, JONES, SNELLING, GILBERT, & DAVIS
Chicago, Illinois
For Claimants

Scott A. White, Esq.
WHITE & RISSE, L.L.P.
St. Louis, Missouri
For the Employer/Carrier

BEFORE: RUDOLF L. JANSEN
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended. 30 U.S.C. § 901 et seq. Under the Act, benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of coal miners whose deaths were caused by pneumoconiosis also may recover benefits. Pneumoconiosis, commonly known as black lung, is defined in the Act as "a chronic dust disease of the lung and its sequelae, including pulmonary and respiratory impairments, arising out of coal mine employment." 30 U.S.C. § 902(b).

On October 8, 1999, this case was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held in Bloomington, Indiana on May 16, 2000. The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, arguments of the parties, and applicable regulations, statutes, and case law. They also are based upon my observation of the appearance and demeanor of the witnesses who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit received into evidence has been reviewed carefully, particularly those related to the miner's medical condition. The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to "DX", "EX", and "CX" refer to the exhibits of the Director, Employer, and Claimant, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

1. Whether the evidence establishes a material change in conditions pursuant to Section 725.309;

2. Whether the evidence establishes a change in conditions or a mistake in a determination of fact pursuant to Section 725.310;

3. Whether Claimant has pneumoconiosis as defined by the Act and regulations;

4. Whether Claimant's pneumoconiosis arose out of coal mine employment;

5. Whether Claimant is totally disabled; and

6. Whether Claimant's disability is due to pneumoconiosis.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

Claimant, Robert J. Finger, was born on January 5, 1929. Mr. Finger originally married Joann Myers on August 14, 1948. They were divorced and later remarried on October 17, 1979. They again divorced and were remarried for a third time on August 14, 1989, and resided together until Mr. Finger's demise. They had no children who were under eighteen or dependent upon them at the time these claims were filed. (DX 01, 34). At the time of the hearing, Mrs. Finger resided in Blanford, Indiana and had not remarried. (DX 34).

Mr. Finger suffered from wheezing, shortness of breath, and persistent coughing. (DX 01, 34) It is consistently represented through out the record that Mr. Finger smoked cigarettes at a rate of between two-thirds and three-quarters of a package of cigarettes per day for a period beginning in 1945 until he quit smoking in 1989. Therefore, I find that Mr. Finger smoked three-quarters of a package of cigarettes per day for forty-four years.

Claimant filed his original application for black lung benefits on August 29, 1989. (DX 26) The Office of Workers' Compensation denied the claim on February 12, 1990. On September 15, 1993, he filed a second claim for benefits. (DX 01) The Office of Workers' Compensation Programs denied the claim on March 9, 1994, and, following an informal conference, affirmed its denial on July 7, 1994. Mr. Finger requested a formal hearing on March 28, 1994, and then again on July 28, 1994. (DX 19, 30)

On September 23, 1995, before the case was heard, Mr. Finger died. (DX 35) At the February 26, 1996 hearing Claimant's counsel indicated that Mr. Finger had died and that Mrs. Finger would be filing a widow's claim to be consolidated with the miner's claim. The claim was remanded on March 6, 1996, and a

widow's claim was filed March 14, 1996. (DX 34) The Director denied the widow's claim on July 9, 1996. (DX 42) The denial of the widow's claim was affirmed on October 25, 1996 and again on June 9, 1997. Mrs. Finger requested a formal hearing on June 16, 1997.

The case was again remanded to the District Director, and again denied on August 3, 1999. (DX 64) Pursuant to Claimant's August 27, 1999 request for a formal hearing, the case was transferred to the Office of Administrative Law Judges for a formal hearing. (DX 67)

Coal Mine Employment

The duration of a miner's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. At the hearing, the parties stipulated that Claimant worked sixteen years in qualifying coal mine work. (Tr. 58) Based upon my review of the record, I accept the stipulation as accurate and credit Claimant with sixteen years of qualifying coal mine employment.

During his mining career, Mr. Finger performed the duties of an electrician, inside laborer, loading machine operator, and shaker operator. (CX 02) In his last coal mine employment as an electrician he was required to carry roof bolt cables weighing in excess of one hundred pounds. He was also required to lift motors weighing sixty to seventy pounds, his tool box weighing seventy-five pounds, and he had to walk approximately one thousand feet through the mines on a regular basis. (CX 03, 05) He was exposed to coal dust in each of these positions. (DX 02)

MEDICAL EVIDENCE

X-ray reports

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 59	09-20-95	09-22-95	Kinnebrew / unknown	Decreased pulmonary edema
DX 59	09-18-95	09-18-95	Konowitz / unknown	Not diagnostic
DX 59	09-16-95	09-16-95	Lambertus / unknown	No change
DX 59	09-14-95	09-14-95	Kinnebrew / unknown	No change

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 59	09-13-95	09-13-95	Lambertus / unknown	Cardiomegaly and congestion
DX 59	09-12-95	09-12-95	Konowitz / unknown	Atelecactic changes
DX 39	07-01-95	07-01-95	Sweeney / unknown	Fibroemphysematous disease
DX 59	06-20-95	06-20-95	Lambertus / unknown	COPD
DX 39	06-05-95	06-05-95	Barron / unknown	Pulmonary interstitial markings
DX 40	05-27-95	05-30-95	Lash / unknown	COPD
DX 40	05-24-95	05-25-95	Dale / unknown	Obstructive lung disease, pulmonary emphysema
DX 59	02-18-95	02-19-95	Katzen / unknown	Chronic inflammation
DX 59	01-21-95	01-21-95	Roca / unknown	COPD
DX 40	11-13-94	11-14-94	Dale / unknown	Obstructive lung disease, pulmonary emphysema
DX 58	10-13-93	09-28-94	Wershba / B	Negative
DX 58	10-13-93	09-19-94	Abramowitz / B	Negative, COPD
DX 58	10-13-93	09-14-94	Binns / B	Negative
DX 58	10-13-93	09-12-94	Gogineni / B	Negative
DX 14	10-13-93	11-20-93	Cole / BCR, B	Negative
DX 28	08-10-93	06-10-94	Gaziano / B	Negative
DX 24	08-10-93	10-22-93	Fisher / BCR, B	2/1
DX 40	01-05-91	01-07-91	Barron / unknown	COPD
DX 40	02-23-90	02-23-90	Hurst / unknown	COPD
DX 40	12-23-89	12-23-89	Sweeney / unknown	Fibroemphysematous changes
DX 26	unknown	10-23-89	Brown / unknown	Negative
DX 26	09-25-89	05-20-90	Morgan / B	Negative
DX 26	09-25-89	02-27-90	Renn / B	Negative

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 26	09-25-89	01-24-90	Tyrrell / BCR, B	Negative
DX 26	09-25-89	01-24-90	Wieland / BCR, B	Negative
DX 26	09-25-89	01-23-90	Bridges / BCR, B	Negative
DX 26	09-25-89	01-23-90	Holdener / BCR, B	Negative
DX 26	09-25-89	10-12-89	Cole / BCR, B	1/0
DX 26	09-25-89	09-25-89	Bathia / BCR	Negative, mild emphysema
DX 26	07-28-89	07-29-89	Littman / unknown	COPD
DX 26	07-20-89	07-21-89	Lambertus / unknown	Negative
DX 26	unknown	06-23-89	Sweeney / unknown	Cardiomegaly
DX 26	06-19-89	06-19-89	Hill / unknown	Cardiomegaly
DX 26	10-18-85	10-21-85	Besozzi / unknown	Fibroemphysematous disease
DX 26	12-09-82	12-09-82	Alexandrescu / unknown	Negative, lungs clear

"BR" denotes a "B" reader and "BCR" denotes a board-certified radiologist. A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successfully completing an examination conducted by or on behalf of the Department of Health and Human Services (HHS). A board-certified radiologist is a physician who is certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. See 20 C.F.R. § 718.202(a)(ii)(C). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

Pulmonary Function Studies

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Tracings	Comments
DX 26 09-25-89	Pangan	60 / 70	1.93	4.44	52	43	Yes	Good effort and cooperation, Consistent with COPD and emphysema
			no change*	52% inc.*	no change*			
DX 26 10-24-89	Pangan	60 / 70	1.37	3.39	48	40	Yes	
			35% inc.*	52% inc.*	40% inc.*			
DX 10 10-13-93	Combs	64 / 70.5	1.25	3.30	52	38	Yes	Good effort, good cooperation
			2.03*	2.59*	81*	78*		
DX 36 11-23-94	Unknown	65 / 70	1.03	3.12	N/A	33	No	Good effort, good cooperation
DX 26 date unknown	Unknown	56 / 72	2.5	4.3	N/A	56	No	Good effort, good cooperation

*post-bronchodilator values

On November 9, 1993, Sarah Brackney Long, M.D., opined that the vents obtained by Daniel Combs, M.D., on October 13, 1993, were acceptable. (DX 11) She opined that the data obtained with regard to pulmonary function on November 23, 1994, was not acceptable as it did not contain three tracings. Dr. Long also opined that the data obtained on September 25, 1989, was an invalid measure of MVV, but that the FEV_1 and FVC values were valid.

James V. Vest, M.D., evaluated the study performed on October 24, 1989. (DX 26) He opined that the study was invalid as a measure of pulmonary function due to sub-optimal effort.

Dr. Vest is Board Certified in Internal Medicine and Pulmonary Disease.

Arterial Blood Gas Studies

Exhibit	Date	pCO_2	pO_2	Resting/ Exercise
DX 59	09-19-95	32	96	Hospital Bedside
DX 36	07-06-95	26	56	Hospital Bedside
DX 59	11-13-94	35	70	Low
		45	95	High
DX 13	10-26-93	35.4	145	Resting
		38.7	78	Exercise
DX 26	09-25-89	36.6	82.9	Resting
		37.1	75.8	Exercise
DX 26	06-18-89	36.1	100.8	

On July 2, 1996, Dr. Long opined with regards to the validity of the July 6, 1995 arterial blood gas study. She noted that the study was performed while Mr. Finger was hospitalized for an illness which was possibly acute. Due to this fact, she opined that the results of the study were invalid.

Narrative Medical Evidence

On October 26, 1993, Daniel Combs, M.D., physically examined Mr. Finger. (DX 12) Dr. Combs reviewed x-rays, pulmonary function studies, and arterial blood gas reports, noting ten years of underground coal mine employment, four years of aboveground coal mine employment, and a three-quarter package of cigarette per day smoking history of forty-four years ending in 1989. In reviewing Mr. Finger's work history, he discussed the strenuous nature of the miner's jobs and duties performed on those jobs. He diagnosed Mr. Finger with chronic obstructive pulmonary disease, coronary artery disease, and pulmonary fibrosis caused by environmental pollutants, including cigarette smoke and coal dust. Dr. Combs opined that Mr. Finger was totally and permanently disabled, and that the disability arose fifty percent due to chronic obstructive pulmonary disease,

twenty percent due to coronary artery disease, and thirty percent due to coal workers' pneumoconiosis. Dr. Combs credentials are not of record.

Mr. Finger was examined by J. F. Pangan, M.D., on September 25, 1989. (DX 26) Besides physically examining Mr. Finger, Dr. Pangan reviewed x-rays, pulmonary function studies, and arterial blood gas studies, and noted ten years of underground coal mine employment, four years of aboveground coal mine employment, and a three-quarter package of cigarette per day smoking history of forty-three years ending in 1989. He opined that Claimant suffered from chronic obstructive pulmonary disease and emphysema, but provided no etiology for these diseases. His opinion does not comment on disability. Dr. Pangan's credentials are not of record.

The record includes reports from Shatilal S. Patel, M.D., dated June 30, 1989, and October 12, 1989, regarding a cardiac catheterization. (DX 26) Dr. Patel noted in both reports significant congestive heart failure and coronary artery disease characterized by left ventricular systolic dysfunction. Dr. Patel made no opinion concerning impairment or etiology. This report was accompanied by portions of his chart and billing statements which contain no medical opinion. Dr. Patel's credentials are not of record.

Mr. Finger was examined on June 18, 1989, by his treating physician, James H. Acklin, M.D. (DX 26) Following a physical examination after being admitted to the hospital, Dr. Acklin opined that Claimant had congestive heart failure secondary to hypertensive cardiovascular disease. Dr. Acklin does not opine as to Mr. Finger's disability, nor to the etiology of his disease. Dr. Acklin's credentials are not of record.

Contained within the record are progress notes and discharge summaries signed by Mr. Finger's attending physician, Raj Jeevan, M.D., chronicling the emergency room visits and hospitalizations prior to Mr. Finger's death. Dr. Jeevan reviewed x-rays and EKGs on a regular basis and opined that Mr. Finger was suffering from chronic obstructive lung disease from black lung and pneumonia, end stage renal failure and multiple organ failure. (DX 38, 53) Dr. Jeevan completed Mr. Finger's final discharge summary following death on September 23, 1995. On that final diagnosis he included severe chronic obstructive lung disease from black lung, suppurative pneumonia versus fluid overload, chronic congestive heart failure and renal failure.

The death certificate and this report listed the cause of death as renal failure and "Black Lung - Severe." (DX 35) Dr. Jeevan is Board Certified in Internal Medicine.

On July 12, 1995, a bronchoscopy with transbronchial biopsy of the left upper lobe was performed on Mr. Finger by Meghasyamaro Theertham, M.D. (DX 39) On July 13, 1995, the tissue from the biopsy was examined by A. Dewitt, M.D. (DX 41) Dr. Dewitt described the tissue as containing anthracotic pigmentation. Based upon his analysis of the tissue, he opined that Mr. Finger had chronic inflammation, pneumonia, and foci of interstitial fibrosis with anthracosis. Drs. Dewitt and Theertham's credentials are not of record.

A hospital examination report dated November 13, 1994, from Melanie J. Mendoza, M.D., diagnoses Mr. Finger with chronic obstructive pulmonary disease, CAD, renal insufficiency and notes a "history of CWP." Claimant had various hospital examinations performed in the last two years of his life. Many of these reports diagnose chronic obstructive pulmonary disease and bronchitis. They also note a history of coal workers' pneumoconiosis and black lung disease, but do not specifically diagnose Mr. Finger as having pneumoconiosis.

The record includes a lung scan interpretation from James B. Kho, M.D. (DX 53) Dr. Kho opines that the results of the lung scan indicate the presence of chronic obstructive pulmonary disease, but no pulmonary emboli. Dr. Kho does not opine as to the etiology of the chronic obstructive pulmonary disease, nor does he comment on disability. Dr. Kho's credentials are not of record.

David Hinkamp, M.D., provided an independent medical review dated April 21, 1999. (DX 61, CX 07) Dr. Hinkamp reviewed x-rays, pulmonary function and arterial blood gas studies, EKGs, lab reports, physical examination reports, and pathology reports. He also noted a fourteen year coal mine history, including an exhaustive list of jobs and duties performed by Mr. Finger, as well as a smoking history consisting of less than thirty-five pack years. Dr. Hinkamp opined that Mr. Finger suffered from chronic obstructive pulmonary disease which was caused by both cigarette smoke and exposure to coal dust. He further opines that prior to his death, Mr. Finger was totally disabled from performing his previous coal mine employment. Dr. Hinkamp states that Claimant's lungs were significantly affected by long term exposure to coal dust, which was a significant

contributor to his chronic obstructive pulmonary disease. Dr. Hinkamp finally opines that the presence of chronic obstructive pulmonary disease foreclosed treatments for Mr. Finger's other medical issues which would have very likely prolonged his life. Dr. Hinkamp is Board Certified in Preventive Medicine.

On April 19, 1999, Robert A. C. Cohen, M.D., provided an independent medical review. (DX 61, CX 06) Dr. Cohen reviewed x-rays, pulmonary function and arterial blood gas studies, EKGs, lab reports, and physical examination reports. Dr. Cohen provided an in-depth employment history noting fourteen years of coal mine employment, listing in detail the jobs and duties performed by Mr. Finger during his career. He also noted a smoking history of two-thirds to three-quarters of a package of cigarettes per day for forty-four years, ending in 1989. Based upon the above evidence, Dr. Cohen diagnosed Mr. Finger with coal workers' pneumoconiosis caused by prolonged exposure to coal dust, and chronic obstructive pulmonary disease substantially caused by cigarettes and exposure to coal dust. He opined that prior to his death, Mr. Finger was totally disabled from his previous coal mine employment due to severe respiratory impairment. He further opined that his respiratory impairment made him more susceptible to the effects of pneumonia from fluid accumulation which resulted from his renal failure and congestive heart failure. Dr. Cohen linked Mr. Finger's death to this susceptibility, opining that Mr. Finger "more likely than not died sooner than he otherwise would have." Dr. Cohen is Board Certified in Internal medicine and Pulmonary Disease, and is a B-reader.

A pathology report dated November 10, 1998 was submitted by Jerrold L. Abraham, M.D. (DX 63) After reviewing slides obtained from a bronchoscopy with transbronchial biopsy of the left upper lobe, he opined that Mr. Finger had interstitial dust accumulation and fibrosis consistent with coal workers' pneumoconiosis. Dr. Abraham is Board Certified in Anatomic Pathology.

A pathology report dated July 9, 1997 was submitted by Richard L. Naeye, M.D. (DX 63, EX 01) Upon reviewing slides of lung tissue, Dr. Naeye noted that there was too little tissue available to determine whether pneumoconiosis was present. He stated that any impairment present in Mr. Finger would have been very mild, and that "simple coal workers' pneumoconiosis does not progress after a miner quits working in the industry." Dr. Naeye was deposed on May 3, 1999. He noted a smoking history of

twenty to forty pack years, and reviewed x-rays, pulmonary function and arterial blood gas studies, and reports of physical examinations. Again he opined that he found no pneumoconiosis because of the limited tissue available for review. Based upon the other evidence reviewed, he did opine that Mr. Finger did not have pneumoconiosis, or if he did it would have been mild. He stated again that simple pneumoconiosis does not progress and, in response to Dr. Abraham's finding of anthracosis, stated that anthracosis is not a finding of pneumoconiosis. Dr. Naeye is Board Certified in Pathology.

An independent medical review dated June 15, 2000, was provided by Steven M. Koenig, M.D. (CX 09) Dr. Koenig reviewed x-rays, pulmonary function and arterial blood gas studies, EKGs, lab reports, physical examination reports, and pathology reports from Drs. Abraham and Naeye. He also noted a fourteen year coal mine employment with an exhaustive list of jobs and duties performed by Mr. Finger throughout his career, as well as a smoking history of less than one package of cigarettes per day from 1945 to 1989. Based upon this evidence, he opined that Mr. Finger had chronic obstructive pulmonary disease caused or significantly contributed to by exposure to coal dust. He further opined that prior to his death, Mr. Finger was totally disabled due to his pulmonary impairment, and that the chronic obstructive pulmonary disease created difficulties in treating his other ailments thereby hastening his death. Dr. Koenig is Board Certified in Internal Medicine, Pulmonary Disease, and Critical Care Medicine.

Kirk E. Hippensteel, M.D., provided an independent medical review dated March 2, 1998. (DX 63, EX 5) Dr. Hippensteel reviewed x-rays, pulmonary function and arterial blood gas studies, lab reports, physical examination reports, hospital reports, death certificate, and pathology reports. He noted that Mr. Finger was an electrician for Zeigler Coal Company and had four additional years in the industry. He did not note a smoking history upon which he based his opinion. Based upon this information, he opined that Mr. Finger did not have coal workers' pneumoconiosis, but that his congestive heart failure and renal failure caused interstitial changes. He comments that the death certificate acknowledging Mr. Finger's death is incomplete in that it does not mention multiple organ failure as a cause of death, nor are the other final diagnoses listed as causing death.

Dr. Hippensteel was deposed on August 19, 1998. (DX 63, EX 11) He opined that Mr. Finger was totally disabled after leaving the mines, but the etiology of the impairment was from various conditions. Dr. Hippensteel was again deposed on July 12, 2000, after reviewing medical reports from Drs. Abraham, Hinkamp, Cohen, and Koenig, and noting a less than one package per day smoking history for forty years. (EX 20) He explained that the pulmonary changes evident in Mr. Finger were a result of sepsis, caused by his gangrene, which lead to pneumonia and multiple organ shutdown. He opined that Mr. Finger had chronic obstructive pulmonary disease caused by smoking cigarettes and prior bronchial infections. He acknowledged that Claimant was totally disabled from a respiratory standpoint, but that the impairment was not due to coal mine employment. He also opined that Mr. Finger's death was not caused, contributed to, or hastened by pneumoconiosis, and that the impairment was not the sole reason for foregoing surgical intervention to prolong his life. Dr. Hippensteel is Board Certified in Internal Medicine and Pulmonary Disease and Critical Care Medicine.

An independent medical review was performed by Joseph J. Renn, M.D., on February 28, 1998. (DX 63, EX 04) Dr. Renn reviewed x-rays, pulmonary function and arterial blood gas studies, EKGs, physical examination reports, and pathology reports. He noted a thirteen year coal mine history, listing jobs held by Mr. Finger through his career, but not duties affiliated with those jobs. He also noted a smoking history of two-thirds to one package of cigarettes per day for forty to forty-four years. Based upon this information , he diagnosed Mr. Finger as suffering from progressive left ventricular cardiac failure due to fluid overload following withdrawal of renal dialysis, and chronic left ventricular failure due to arteriosclerotic cardiomyopathy and arterial septal defect. He opined that Mr. Finger had a moderately severe to severe obstructive defect, but that his death was not caused, contributed
to, or hastened by exposure to coal dust. Dr. Renn is Board Certified in Internal Medicine and Pulmonary Disease, and is a B-reader.

Peter G. Tuteur, M.D., presented an independent medical review dated February 17, 1998. (DX63, EX 03) Dr. Tuteur reviewed x-rays, pulmonary function and arterial blood gas studies, hospital reports, lab reports, physical examination reports, and a pathology report from Dr. Naeye. He noted a fourteen year coal mine history and a forty-five year smoking

history of up to one package of cigarettes per day. Based upon this information, Dr. Tuteur diagnosed Claimant with chronic obstructive pulmonary disease and emphysema, but opined that he did not have clinically, radiographically, pathologically, or physiologically significant pneumoconiosis. He further opined that Mr. Finger's death was in no way related to, aggravated by, or caused by the inhalation of coal dust.

Dr. Tuteur was deposed on August 17, 1998. (DX 63, EX 10) He again opined that Mr. Finger suffered from cigarette induced chronic obstructive pulmonary disease and not clinically, radiographically, pathologically, or physiologically significant pneumoconiosis. He further opined that Mr. Finger did not have total disability that was related to coal dust exposure, nor was dust exposure a substantially contributing cause of death. Dr. Tuteur was again deposed on July 18, 2000. (EX 19) After reviewing medical reports from Drs. Abraham, Hinkamp, Cohen, and Koenig, he again opined that Mr. Finger had chronic obstructive pulmonary disease from tobacco smoke. He further opined that Claimant was totally disabled by 1993 and that the presence of chronic obstructive pulmonary disease hastened Mr. Finger's death. Dr. Tuteur is Board Certified in Internal Medicine and Pulmonary Disease.

DISCUSSION AND APPLICABLE LAW

LIVING MINER'S CLAIM

Because Claimant filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. To establish entitlement to benefits under this part of the regulations, a claimant must prove by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. *See, Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989). In *Director, OWCP v. Greenwich Collieries, et al.*, 114 S. Ct. 2251 (1994), the U.S. Supreme Court stated that where the evidence is equally probative, the claimant necessarily fails to satisfy his burden of proving the existence of pneumoconiosis by a preponderance of the evidence.

I must first determine whether Mr. Finger's claim filed on September 15, 1993, constitutes a duplicate claim or a request

for modification. I must then determine if Claimant has demonstrated a material change in conditions under 20 C.F.R. §725.309 or a change in conditions or mistake in a determination of fact pursuant to 20 C.F.R. §725.310 before considering whether the evidence of record establishes entitlement to benefits.

Finally, I must consider Mrs. Finger's claim for survivor benefits, and whether it constitutes a request for modification of Mr. Finger's claim. Because Mrs. Finger filed her application for survivor's benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. To establish entitlement to benefits under this part of the regulations, she must prove by a preponderance of the evidence that the miner had pneumoconiosis, that his pneumoconiosis arose from coal mine employment, and that his death was due to pneumoconiosis. ***Peabody Coal Co. v. Director, OWCP,*** 972 F.2d 178 (7th cir. 1992).

Modification

Section 725.310 provides that a claimant may file a petition for modification within one year of the last denial of benefits. In this case, the denial of benefits with regards to Mr. Finger's previous claim occurred on February 12, 1990. He filed his second claim for benefits on September 15, 1993, more than three years later. Mr. Finger's claim does not constitute a modification, but is a duplicate claim filed longer than one year after the previous claim was denied. Mrs. Finger's claim is, likewise, not a modification request as Mr. Finger's duplicate claim had not reached a final adjudication at the time she filed her claim.

Duplicate Claim

Claimant's previous claim for benefits was denied on February 12, 1990. As a result, the claim involved in this proceeding, filed on September 15, 1993, constitutes a "duplicate claim" under the regulations. The provisions of Section 725.309(d) apply to duplicate claims and are intended to provide relief from the traditional notions of *res judicata*. Under Section 725.309(d), duplicate claims "must be denied on the grounds of the prior denial unless the evidence demonstrates "a material change in condition." 20 C.F.R. § 725.309(d). The United States Courts of Appeals have developed divergent

standards to determine whether a material change in conditions has occurred. Because Claimant last worked as a coal miner in the state of Illinois, the law as interpreted by the United States Court of Appeals for the Seventh Circuit applies to this claim. *Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989).

Under the Seventh Circuit's standard for establishing a material change in conditions, a claimant "must show that something making a difference has changed" since the prior final denial. *Peabody Coal Co. v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997). Thus, "a claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial", and "[h]is theory of recovery on the new claim must be consistent with the assumption that the original denial was correct." *Id*. If the earlier dismissal was premised upon the failure to show pneumoconiosis, the material change could be evidence showing that the disease has now manifest itself. *Id.* In applying this standard, the administrative law judge must consider all of the new evidence, both favorable and unfavorable, to determine whether it establishes at least one of the elements of entitlement that formed the basis for the prior denial. If the new evidence establishes the existence of one of these elements, it will demonstrate a material change in conditions as a matter of law. Then, the administrative law judge must consider whether all the evidence of record, including evidence submitted with the prior claims, supports a finding of entitlement to benefits. *Id*. at 1008-09.

In the denial of Claimant's prior claim, the Director determined that the evidence failed to establish pneumoconiosis, causation, and total disability due to pneumoconiosis. If the newly-submitted evidence establishes one of these elements, it will demonstrate a material change in conditions. Then, I must review the entire record to determine entitlement to benefits. See Spese, 117 F.3d at 1008.

Review of New Medical Evidence: Pneumoconiosis

Under the Act, "'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment." 30 U.S.C. § 902(b). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Under Section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. In evaluating the x-ray evidence, I assign

heightened weight to interpretations of physicians who qualify as either a board-certified radiologist or "B" reader. *See Dixon v. North Camp Coal Co.*, 8 BLR 1-344, 1-345 (1985). I assign greatest weight to interpretations of physicians with both of these qualifications. *See Woodward v. Director, OWCP*, 991 F.2d 314, 316 n.4 (6th Cir. 1993); *Sheckler v. Clinchfield Coal Co.*, 7 BLR 1-128, 1-131 (1984).

The new evidence of record contains twenty-five interpretations of nineteen chest x-rays. Of these interpretations, eighteen were negative for pneumoconiosis while one was positive. The remainder of the x-rays were not diagnostic with regards to pulmonary disease. One positive reading was from a dually qualified physician, and one negative reading was from a dually qualified physician. In addition to the negative interpretation by the dually qualified physician, seven of the negative interpretations were from B readers. Because the negative readings constitute the overwhelming majority of interpretations and are verified by highly-qualified physicians, I find that the x-ray evidence fails to support a finding of pneumoconiosis.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. In this case, pathology reports were filed by Drs. Abraham, Dewitt, and Naeye, analyzing tissue samples obtained from a bronchoscopy with transbronchial biopsy of the left upper lobe. Dr. Dewitt opined that the tissue samples showed anthracotic pigmentation. He opined, based upon his analysis, that Mr. Finger had foci of interstitial fibrosis with anthracosis. A biopsy finding of anthracotic pigmentation is not sufficient, by itself, to establish the existence of pneumoconiosis. *See* 20 C.F.R. §718.202(a)(2); *Griffith v. Director, OWCP*, 49 F.3d 184, 19 BLR 2-111, 2-117 (6th Cir. 1995). A diagnosis of anthracosis is, however, sufficient to establish the existence of pneumoconiosis. 20 C.F.R. §718.201(a).

Dr. Abraham, a Board Certified Pathologist, opined that Mr. Finger had interstitial dust accumulation and fibrosis consistent with pneumoconiosis. Dr. Naeye, also a Board Certified Pathologist, noted that there was insufficient tissue to form a diagnosis. He went on to opine, based upon the other medical evidence, that Mr. Finger does not have pneumoconiosis, explaining that pneumoconiosis did not progress once a miner left the mines. It has long been held that pneumoconiosis is a

progressive and irreversible disease. See, *Peabody Coal Co. v. Spese*, 117 F.3d 1001 (7th Cir., 1997). Dr. Naeye has based his opinion on a fact that is clearly against the case law of the Seventh Circuit, entitling his opinion to less weight. Further, Dr. Naeye's opinion is not based upon the biopsy evidence, which he found insufficient tissue to form a diagnosis, rather he bases his opinion upon a review of the other evidence presented in this case. Therefore, his opinion regarding biopsy evidence of pneumoconiosis is entitled to further diminished weight as it is not based upon the biopsy evidence.

In weighing the biopsy evidence I am faced with the opinion of a highly qualified pathologist opining to the presence of pneumoconiosis, and a highly qualified pathologist, whose opinion is entitled to diminished weight, opining that Claimant does not have pneumoconiosis. I must also consider Dr. Dewitt's opinion, though his credentials are unknown, diagnosing anthracosis. I find that the opinions of Drs. Abraham and Dewitt are sufficient to support a finding of pneumoconiosis through biopsy evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions apply to this claim, Claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides that a claimant may establish the presence of pneumoconiosis through a reasoned medical opinion. Although the x-ray evidence does not establish pneumoconiosis, a physician's reasoned opinion nevertheless may support the presence of the disease if it is explained by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986).

Dr. Combs specifically found chronic obstructive pulmonary disease, coronary artery disease, and pulmonary fibrosis. These diagnosis alone are not a positive finding of pneumoconiosis, however, Dr. Combs attributes these conditions to environmental

pollutants including cigarette smoke and coal dust. He then goes on to attribute thirty percent of Mr. Finger's total disability to coal workers' pneumoconiosis. Drs. Cohen and Hinkamp opined that Mr. Finger suffered from coal workers' pneumoconiosis. In arriving at these conclusions each of these physicians considered accurate employment and smoking histories and reviewed the objective data. I find each of these opinions regarding the presence of pneumoconiosis to be well reasoned and documented. See, *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Dr. Cohen is highly qualified with Board Certifications in both internal medicine and pulmonary disease entitling his opinion to significant weight.

Dr. Koenig diagnosed Mr. Finger with chronic obstructive pulmonary disease and opined that it was caused or significantly contributed to by exposure to coal dust. He reviewed the objective evidence and cited to accurate work and social histories. Dr. Koenig is highly qualified with Board Certifications in internal medicine, pulmonary disease, and critical care medicine. Based upon his credentials, documentation, and reasoning, Dr. Koenig's opinion is entitled to substantial weight. See, *Fields, supra.*

Dr. Jeevan was Mr. Finger's attending physician during his final hospitalization. He treated Claimant continuously for a period spanning almost three months. Dr. Jeevan diagnosed Mr. Finger as having chronic obstructive lung disease from black lung and pneumonia, as well as end stage renal failure. Throughout the time that he was Mr. Finger's attending physician he reviewed x-rays and EKGs, but it is not indicated that he reviewed other medical reports, or the remainder of the objective data. A comparison of medical reports and tests over a long period of time may conceivably provide a physician with a better perspective than the pioneer physician. *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992). It is not evident from the record that Dr. Jeevan compared medical reports and tests. Further, Dr. Jeevan does not discuss relevant social and employment histories to arrive at his conclusions. I therefore find his opinion to be inadequately documented and reasoned and entitled to diminished weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc).

Dr. Tuteur found that Mr. Finger did not have clinically, radiographically, physiologically, or pathologically significant coal workers' pneumoconiosis. In *Mooney v. Peabody Coal Co.*,

BRB 93-1507 B.L.A. (Oct. 30, 1996) the Benefits Review Board deferred to the administrative law judge's reasonable interpretation that "Dr. Tuteur's diagnosis of no 'significant' coal worker's pneumoconiosis, was a finding of 'insignificant' coal worker's pneumoconiosis, which was a positive finding of pneumoconiosis under section 718.202(a)(4)." I find this diagnosis to be a positive finding for coal worker's pneumoconiosis. In finding insignificant pneumoconiosis, Dr. Tuteur reviewed the objective medical data and considered Mr. Finger's employment and social histories. I find his opinion to be well documented and reasoned. See, *Fields, supra*.

Dr. Hippensteel opines that Mr. Finger did not have coal workers' pneumoconiosis, but that he suffered from congestive heart failure and renal failure which caused interstitial changes. He reviews the objective data, and in his first deposition describes the employment and smoking histories upon which he relies. Dr. Hippensteel is highly qualified with Board Certifications in internal medicine, pulmonary disease and critical care medicine. I find his opinion to be adequately documented and reasoned. See, *Fields, supra.*

Dr. Renn's independent medical review is silent with respect to the presence or absence of pneumoconiosis. He opines that Mr. Finger's death was not hastened by exposure to coal dust, but does not opine to the presence or absence of a disease process. A report that is silent on an issue is not probative of that issue. The record contains hospital progress notes and discharge summaries which are also silent as to the presence or absence of pneumoconiosis. Many of these reports list a history of pneumoconiosis but do not specifically make a diagnosis. These reports are silent on this issue and therefore not probative.

As noted above, the x-ray interpretations contained within the record do not support a finding of pneumoconiosis. Weighing the medical evidence together, however, I am faced with Drs. Combs, Cohen, Hinkamp, Jeevan, Koenig and Tuteur, four of which are board certified in pulmonary disease, opining to the presence of pneumoconiosis. Dr. Hippensteel, though also board certified in pulmonary disease, opines to the absence of pneumoconiosis. Drs. Hippensteel and Koenig are also Board Certified in the Internal Medicine Sub-specialty of Critical Care Medicine, making these two physicians of equal certifications in the field of internal medicine. According to

his curriculum vitae, Dr. Koenig, however, has numerous publications and lectures in the fields of occupational lung disease, chronic obstructive pulmonary disease, restrictive pulmonary disease, and smoking compared to occupational lung disease. According to Dr. Hippensteel's curriculum vitae, he has no publications or lectures regarding the issues pertinent to this case. Further, Dr. Koenig's opinion is supported by two other board certified physicians whose opinions are well documented and reasoned. Accordingly, I find Dr. Koenig's opinion, bolstered by those of Drs. Cohen and Tuteur to be of dispositive weight.

The weight of the evidence demonstrates pneumoconiosis by a preponderance. Therefore, I find that Mr. Finger had coal workers' pneumoconiosis. This constitutes a material change in conditions in that the director found no pneumoconiosis in the previous claim. Claimants have established a material change in conditions pursuant to 20 C.F.R. § 725.309, warranting a complete review of the record.

Full Review of the Record: Pneumoconiosis

In addition to the twenty-five x-ray interpretations since the denial of the last claim, the record contains fourteen interpretations from the previous claim. Of the thirty-nine total interpretations of twenty-seven chest x-rays, twenty-nine were negative for pneumoconiosis while only two were positive. These two positive interpretations were by dually qualified physicians, but five negative interpretations were from dually qualified physicians. Also worthy of noting is the fact that W. S. Cole, M.D., read an x-ray as positive in 1989, and read one as negative in 1993. Dr. Cole does not explain the change in his interpretation, thereby entitling his readings to diminished weight. *Hopton v. U.S. Steel Corp.*, 7 B.L.R. 1-12 (1984); *Surma v. Rochester & Pittsburgh Coal Co.*, 6 B.L.R. 1-799 (1984). Because the negative readings constitute the majority of interpretations and are verified by more, highly-qualified physicians, I find that the x-ray evidence fails to support a finding of pneumoconiosis.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy evidence. There was no biopsy evidence developed in the previous claim. Accordingly, my finding that the biopsy evidence supports a finding of pneumoconiosis is as described above.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions apply to this claim, Claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides that a claimant may establish the presence of pneumoconiosis through a reasoned medical opinion. Although the x-ray evidence does not establish pneumoconiosis, a physician's reasoned opinion nevertheless may support the presence of the disease if it is explained by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986).

In addition to the evidence weighed above, the record contains medical opinions from the previously denied claim. J. F. Pangan, M.D., physically examined Mr. Finger, opining that he had chronic obstructive pulmonary disease and emphysema. He did not opine as to an etiology for these conditions. Since he did not relate these pulmonary conditions to coal dust exposure pursuant to §718.201, I find that this diagnosis is negative for pneumoconiosis. Dr. Pangan's opinion adequately documents the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. See, *Fields, supra.* His opinion is well reasoned in that these diagnoses are supported by the underlying facts. *Id*.

The record also contains a cardiac catheterization report from Dr. Patel, which does not opine as to Mr. Finger's pulmonary status. A report from Dr. Acklin likewise does not opine as to pulmonary condition. These opinions are silent as to the presence of pneumoconiosis and therefore not probative of this issue.

Again, the x-ray interpretations contained within the record do not support a finding of pneumoconiosis. Weighing the medical evidence together, however, I am still faced with Dr. Koenig's opinion, bolstered by the other physicians noted above, opining to the presence of pneumoconiosis. The additional

evidence obtained from a review of the full record reveals one physician whose credentials are unknown opining as to pulmonary defect but providing no etiology. As discussed above, the weight of the evidence demonstrates pneumoconiosis by a preponderance. Therefore, I find that Claimants have demonstrated by a preponderance of the evidence that Mr. Finger had coal workers' pneumoconiosis. See, *Greenwich Collieries, supra.*

Full Review of the Record: Causation of Pneumoconiosis

Once pneumoconiosis has been established, the burden is upon the Claimant to demonstrate by a preponderance of the evidence that the pneumoconiosis arose out of Mr. Finger's coal mine employment. 20 C.F.R. § 718.203(b) provides:

> If a miner who is suffering or has suffered from pneumoconiosis was employed for ten years or more in one or more coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of such employment.

I have found that Mr. Finger was a coal miner for sixteen years, and that he had pneumoconiosis. Claimants are entitled to the presumption that Mr. Finger's pneumoconiosis arose out of his employment in the coal mines. No physician opining as to the presence of pneumoconiosis offers an alternative cause to rebut this presumption. See, *Smith v. Director, OWCP,* 12 BLR 1-156 (1989). Therefore, I find that Mr. Finger's pneumoconiosis arose from his coal mine employment.

Full Review of the Record: Total Disability

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204(b)(2). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 BLR 1-11, 1-15 (1991). Section 718.204(c) provides several criteria for establishing total disability. Under this section, I first must evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike, to determine whether Claimant has established total respiratory disability. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195, 1-198 (1987).

Under Sections 718.204(c)(1) and (c)(2), total disability may be established with qualifying pulmonary function studies or arterial blood gas studies. A "qualifying" pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(c)(1), (c)(2). A "non-qualifying" test produces results that exceed the table values. In this case Mr. Finger did not demonstrate disability through qualifying arterial blood gas studies. Mr. Finger did, however, produced qualifying results in valid pulmonary function studies.

Section 718.204(c)(3) provides that a claimant may prove total disability through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

Under Section 718.204(c)(4), total disability may be established if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work. Drs. Combs, Cohen, Hinkamp, Hippensteel, Koenig, and Tuteur opine that Mr. Finger was totally disabled from his previous coal mine employment. Dr. Renn opines that Mr. Finger had a moderately severe to severe obstructive defect, but does not cite to the duties performed during his last coal mine employment. Without such citation of the duties of his previous coal mine employment, I find that Dr. Renn's opinion is not well documented or reasoned with respect to the issue of total disability and therefore entitled to less weight. See, *Clark, supra*.

Weighing all the evidence together I am faced with qualifying pulmonary function studies and medical opinions demonstrating that Mr. Finger was, in fact, totally disabled from a respiratory standpoint. There has not been one well documented and reasoned opinion offered to show that Mr. Finger was not totally disabled. Claimants have therefore demonstrated by a preponderance of the evidence that Mr. Finger was indeed totally disabled from a respiratory standpoint. See, *Greenwich Collieries, supra*.

Full Review of the Record: Total Disability due to Pneumoconiosis

It is not enough that a miner is totally disabled and has pneumoconiosis. Section 718.204(a) provides for benefits for miners who are totally disabled due to pneumoconiosis. See, ***Hawkins v. Director, OWCP,*** 907 F.2d 697 (7th Cir. 1990). The miner must show that his coal dust induced disease contributed to his disability, and that mining was a necessary condition of the miner's disability. ***Id.***

Dr. Combs found Mr. Finger to have pulmonary fibrosis, chronic obstructive pulmonary disease and coronary artery disease caused by environmental pollutants including cigarette smoke and coal dust exposure. He attributed thirty percent of Mr. Finger's total disability to coal workers' pneumoconiosis. Likewise, Drs. Cohen, Hinkamp, and Koenig found that Mr. Finger had chronic obstructive pulmonary disease at least substantially caused by coal dust exposure. These physicians also found Mr. Finger totally disabled by the respiratory impairment resulting from this coal dust induced chronic obstructive pulmonary disease.

Drs. Hippensteel and Tuteur opined that Mr. Finger's disability was not due to pneumoconiosis. Dr. Hippensteel did not find pneumoconiosis present in Mr. Finger. Opinions regarding the etiology of disability from physicians who did not diagnose pneumoconiosis may be accorded less probative weight. ***Peabody Coal Co. v. Shonk***, 906 F.2d 264 (7th Cir. 1990). Dr. Hippensteel's opinion with regards to etiology of total disability is entitled to less weight. Dr. Tuteur diagnosed Mr. Finger with insignificant coal workers' pneumoconiosis, and opined that coal dust exposure had nothing to do with Mr. Finger's total disability. His opinion is well documented and reasoned on this issue.

It is Claimants' burden to demonstrate by a preponderance of the evidence that Mr. Finger was totally disabled due to his pneumoconiosis. The medical evidence presents well documented and reasoned medical opinions finding total disability due to pneumoconiosis including: Drs. Cohen and Koenig, both highly qualified, board certified physicians in the field of pulmonary disease; Dr. Hinkamp, Board Certified in Preventive Medicine; and Dr. Combs, with unknown qualifications. Dr. Tuteur, also Board Certified in Pulmonary Disease, opines to the contrary in

a well documented and reasoned report. Dr. Koenig is Board Certified in Internal Medicine with sub-specialties in Pulmonary Disease and Critical Care Medicine. Dr. Tuteur is Board Certified in Internal Medicine with a single sub-specialty in Pulmonary Disease. According to his curriculum vitae, Dr. Koenig has numerous publications and lectures in the fields of occupational lung disease, chronic obstructive pulmonary disease, restrictive pulmonary disease, and smoking compared to occupational lung disease. Dr. Tuteur's curriculum vitae presents one lecture on occupational pulmonary disease, one abstract on diagnosing pneumoconiosis, and one chapter of instructional materials on chronic obstructive lung disease. Based upon Dr. Koenig's board certifications, curriculum vitae, and the bolstering opinions of other highly qualified physicians, I find Dr. Koenig's opinion to be of substantial weight. Accordingly, I find that Claimants have demonstrated by a preponderance of the evidence that Mr. Finger was totally disabled due to pneumoconiosis.

Claimant, Robert Finger, has demonstrated by a preponderance of the evidence that he had pneumoconiosis which arose out of his coal mine employment, and that he was totally disabled due to his pneumoconiosis. See, *Greenwich Collieries, supra*. Upon such a showing, he is entitled to benefits.

SURVIVOR'S CLAIM FOR BENEFITS

Death due to Pneumoconiosis

Upon demonstrating pneumoconiosis which arose out of Mr. Finger's coal mine employment, Mrs. Finger is entitled to benefits as Mr. Finger's survivor if she demonstrates that his death was due to pneumoconiosis. 30 U.S.C. § 901(a); 20 C.F.R. § 718.205(a). 20 C.F.R. § 718.205(c) provides that:

> For the purpose of adjudicating survivors' claims filed on or after January 1, 1982, death will be considered to be due to pneumoconiosis if any of the following criteria is met:
>
> 1. Where competent medical evidence established that the miner's death was due to pneumoconiosis, or

2. Where pneumoconiosis was a substantially contributing cause or factor leading to the miner’s death or where the death was caused by complications of pneumoconiosis, or

3. Where the presumption set forth at §718.304 is applicable.

4. However, survivors are not eligible for benefits where the miner’s death was caused by traumatic injury or a principal cause of death was a medical condition not related to pneumoconiosis, unless pneumoconiosis was a substantially contributing cause of death.

The United States Court of Appeals for the Seventh Circuit, within whose jurisdiction the instant case arises, has held that pneumoconiosis will be considered a substantially contributing cause of the miner's death if it actually hastened the miner's death, even if only briefly. *Peabody Coal Co. v. Director, OWCP [Railey]*, 972 F.2d 178, 16 BLR 2-121 (7th Cir. 1992). Mrs. Finger has the burden of demonstrating by a preponderance of the evidence that pneumoconiosis was a substantially contributing cause of Mr. Finger’s death.

Mr. Finger died at 9:04 a.m. on September 23, 1995. His death certificate indicates that he died of chronic renal failure with a significant condition of “black lung - severe.” A death certificate, in and of itself, is an unreliable report of the miner's condition and it is error for a judge to accept conclusions contained in such a certificate where the record provides no indication that the individual signing the death certificate possessed any relevant qualifications or personal knowledge of the miner from which to assess the cause of death. *Smith v. Camco Mining, Inc.*, 13 B.L.R. 1-17 (1989); *Addison v. Director, OWCP*, 11 B.L.R. 1-68 (1988). In this case the death certificate was signed by Dr. Jeevan, who was Mr. Finger’s attending physician for his final hospitalizations. Dr. Jeevan also wrote the final diagnoses for Mr. Finger following his death, which included a diagnosis of severe chronic obstructive pulmonary disease from black lung with suppurative pneumonia versus fluid overload. While he did not compare medical reports and data, he did observe firsthand the rapid decline in Mr. Finger’s health which ultimately lead to his demise. Based upon this observation, his opinion is entitled to significant weight.

Dr. Hinkamp attributed Mr. Finger's chronic obstructive pulmonary disease in part to coal dust exposure. He opined that the presence of the obstructive defect prevented aggressive treatments of his gangrene and renal failure, which would have very likely prolonged his life. Dr. Cohen diagnosed Mr. Finger with coal workers' pneumoconiosis and chronic obstructive pulmonary disease caused in part by coal dust. He opined that the respiratory impairment made him more susceptible to the effects of pneumonia from fluid overload, which was caused by either the renal failure or fluid accumulation from the congestive heart failure. This susceptibility from the severe respiratory impairment, he further opined, hastened Mr. Finger's death.

Dr. Koenig agrees with both Drs. Hinkamp and Cohen, opining that the coal dust induced obstructive defect complicated treatment and recovery for Mr. Finger. He states that Mr. Finger had more difficulty recovering from the fluid accumulations in his lungs because of the existing impairment, which made it more difficult to recover from the renal failure. He opines that the obstructive defect hastened Mr. Finger's death.

Dr. Tuteur agrees with Drs. Cohen, Hinkamp, and Koenig, in that he opines that chronic obstructive pulmonary disease did hasten Mr. Finger's death. He disagrees with these physicians as to the cause of the defect, opining that it was caused by cigarette smoke. Dr. Tuteur did, however, find insignificant coal workers' pneumoconiosis in Mr. Finger.

Dr. Hippensteel opined that pneumoconiosis did not contribute to Mr. Finger's death. He stated on deposition that Mr. Finger died from multi-organ failure precipitated by pneumonia and gangrene. He opined that multi-organ failure had a higher mortality rate than single organ failure, but that the likelihood of developing respiratory distress is not higher in a patient with chronic obstructive pulmonary disease. He further opined that the surgical interventions warranted to address Mr. Finger's gangrene and renal failure were not foreclosed by his pulmonary impairment.

An administrative law judge may permissibly accord less weight to an opinion regarding causation where it is based on a faulty underlying premise regarding the presence or absence of pneumoconiosis. *Trujillo v. Kaiser Steel Corporation*, 8 BLR 1-472 (1986); See *Hobbs v. Clinchfield Coal Co.*, 45 F.3d 819, 19

BLR 2-86 (4th Cir. 1995); *Bobick v. Saginaw Mining Company*, 13 BLR 1-52 (1989). Dr. Hippensteel acknowledges the presence of an obstructive defect but opines that Mr. Finger did not have pneumoconiosis or any other coal dust induced defect. I therefore find his opinion entitled to less weight on causation of death.

Dr. Naeye opines on deposition that Mr. Finger did not have pneumoconiosis nor did it hasten his death. Dr. Naeye states that anthracosis is not pneumoconiosis, and that simple pneumoconiosis can't progress after cessation of dust exposure. As mentioned above, 20 C.F.R. §718.201 defines pneumoconiosis as including anthracosis. Also, as mentioned above, pneumoconiosis has been found to be a progressive disease. See, ***Spese, supra.*** Dr. Naeye has based his opinion on facts that are clearly against the regulations and the case law of the Seventh Circuit, entitling his opinion to less weight.

Dr. Renn did not diagnose pneumoconiosis, but opined that Mr. Finger suffered from a moderately severe to severe obstructive defect. He further opined that Mr. Finger's death was not caused, contributed to, or hastened by exposure to coal mine dust, but was as a result of cardiac failure owing to fluid overload following withdrawal of renal dialysis, arteriosclerotic cardiomyopathy, and atrial septal defect. Dr. Renn's opinion is entitled to less weight regarding the causation of death due to a faulty underlying premise, specifically, the absence of pneumoconiosis. See, ***Hobbs, supra; Bobick, supra***.

In weighing the evidence together, I am faced with four physicians opining that coal workers' pneumoconiosis hastened Mr. Finger's death. Of these four physicians, two are board certified in pulmonary disease and one is his attending physician. Conversely, there are four physicians opining that pneumoconiosis did not hasten his death, three of which are board certified in pulmonary disease. All of these physicians, however, are entitled to diminished weight due to the erroneous underlying premise that the miner did not have pneumoconiosis, except Dr. Tuteur. Again, I find that Dr. Tuteur is less qualified than Dr. Koenig to render an opinion on the role of pneumoconiosis in Mr. Finger's death due to Dr. Koenig's superior credentials, curriculum vitae, and the bolstering opinions of other highly qualified physicians including Mr. Finger's attending physician. I find that the weight of the

medical evidence demonstrates by a preponderance of the evidence that Mr. Finger's death was at least hastened by his pneumoconiosis.

As discussed above, I have found based upon the medical evidence that Robert Finger had coal workers' pneumoconiosis. Claimant Joann Finger has further demonstrated by a preponderance of the evidence that her husband, Robert Finger, died due to his pneumoconiosis, entitling her to survivor benefits.

ENTITLEMENT

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of the onset of total disability. Where the evidence does not establish the month of the onset of total disability, benefits begin with the month during which the Claimant filed his application for benefits. *Lykins v. Director, OWCP,* 12 BLR 1-181 (1989). Based upon my review of the record and the limited evidence provided, I cannot determine the month that Claimant became totally disabled due to pneumoconiosis. Consequently, Mr. Finger shall receive benefits commencing September 1993, the month during which this duplicate claim was filed.

Further, it is concluded that Claimant Joann Finger is entitled to benefits. 20 C.F.R. Section 725.503(c) provides as follows:

> Except as is provided in Part 727 of this subchapter, in the case of a survivor of a miner who died due to or while totally disabled by pneumoconiosis, benefits shall be payable beginning with the month of the miner's death, or January 1, 1974, whichever is later.

Where it is determined that the miner died due to pneumoconiosis, entitlement to benefits properly commences as of the first day of the month of the year of the miner's demise. *Mihalek v. Director, OWCP*, 9 BLR 1-157 (1986). The miner died on September 23, 1995. Therefore, Joann Finger is entitled to benefits commencing on September 1, 1995.

ORDER

The Employer, Zeigler Coal Company, is HEREBY ORDERED to pay:

1. To the Representative of Robert J. Finger, all benefits to which the miner was entitled under the Act commencing September 1, 1993, and ending at his death on September 1995;

2. To the Representative of Robert J. Finger, all medical and hospitalization benefits to which the miner was entitled commencing September 1, 1993, and ending at the time of his death, September 1995, or otherwise provide for such service; and

3. To the Secretary of Labor, reimbursement for any payment the Secretary has made to the Claimant under the Act and to deduct such amounts, as appropriate, from the amount the Employer is Ordered to pay under paragraphs 1 and 2 above.

4. To Claimant Joann Finger all benefits to which she is entitled under the act commencing September 1, 1995.

A
Rudolf L. Jansen
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty (30) days from the date of this Decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington D.C. 20013-7601. A copy of this Notice of Appeal also must be served on Donald S.

Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.